

Aswad Surgical Group Health History Questionnaire

Name: _____
 Pharmacy: _____
 Best contact number: _____

Date of Birth: _____ Age: _____
 Primary Care Provider: _____
 Email: _____

Things I would like to discuss with the provider today:

1. _____ 2. _____

PERSONAL MEDICAL HISTORY

Chronic Medical Conditions (please check all that apply):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back pain | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Acid Reflux (GERD) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Crohn's | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> PE |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Chronic pain for which I see a pain clinic | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ | |

Previous Surgeries/Procedures (please check all that apply):

- | | | | |
|---|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> CABG | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart stent(s) | <input type="checkbox"/> Mastectomy | _____ |
| <input type="checkbox"/> Total Hysterectomy | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Colonoscopy | _____ |
| <input type="checkbox"/> Partial Hysterectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> EGD | _____ |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Orthopedic | |

Height: _____	Weight: _____	Do you take Aspirin? _____ Yes _____ No
Allergic to Latex? _____ Yes _____ No		Do you take Plavix? _____ Yes _____ No
Sensitive to Latex? _____ Yes _____ No		Do you take a blood thinner? _____ Yes _____ No
		Problems with anesthesia? _____ Yes _____ No

Allergies and/or Intolerance to Medications:

Medications you are taking including over-the-counter meds/supplements (with dose & frequency):

Check here if you have a Medication List and we will make a copy.

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SOCIAL HISTORY

Marital Status ___ Single ___ Married ___ Divorced ___ Widowed	Number of Children ___
Do you use smoke now? ___ Yes ___ No How much? _____ How long? _____	Occupation _____
Do you use chew/snuff? ___ Yes ___ No	Does your job entail heavy lifting? ___ Yes ___ No
Have you used tobacco before? ___ Yes ___ No	Alcohol _____ drinks per week
Street drugs? _____	Caffeine _____ cups per day (coffee, tea, soda)
	Water _____ cups per day

FAMILY HISTORY

	Living (Yes/No)	List medical conditions (diabetes, cancer, heart disease, etc.)
Father	___ Yes ___ No	_____
Mother	___ Yes ___ No	_____
Brother(s)		_____
Sister(s)		_____
Children		_____

REVIEW OF SYSTEMS (please check all that apply)

<p>Systemic symptoms</p> <input type="checkbox"/> Weight change <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Feeling tired <p>Head symptoms</p> <input type="checkbox"/> Headache <input type="checkbox"/> Facial pain <input type="checkbox"/> Sinus pain <p>Eye symptoms</p> <input type="checkbox"/> Eyesight problems <input type="checkbox"/> Eye pain <p>Ear/Nose/Throat Symptoms</p> <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Hoarseness <input type="checkbox"/> Throat pain <p>Neck symptoms</p> <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Lump/swelling neck	<p>Breast symptoms</p> <input type="checkbox"/> Breast pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breast Lump <p>Heart symptoms</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Fast heart rate <input type="checkbox"/> Palpitations <p>Pulmonary symptoms</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <p>GI symptoms</p> <input type="checkbox"/> Change in appetite <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Black stool <input type="checkbox"/> Bloody stool <input type="checkbox"/> Rectal pain <input type="checkbox"/> Hernia	<p>Urinary symptoms</p> <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <p>Skin symptoms</p> <input type="checkbox"/> Abscess <input type="checkbox"/> Cyst <input type="checkbox"/> Rash <input type="checkbox"/> Itching <p>Endocrine symptoms</p> <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger <p>Musculoskeletal Symptoms</p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle pain <p>Neurological symptoms</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> Fainting <input type="checkbox"/> Weakness <input type="checkbox"/> Sensation changes	<p>Psychological Symptoms</p> <input type="checkbox"/> Insomnia <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Stress <p>Other symptoms</p> <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <p>Recent Radiology/Tests</p> <input type="checkbox"/> EGD Date _____ <input type="checkbox"/> Colonoscopy Date _____ <input type="checkbox"/> Mammogram <input type="checkbox"/> Breast Ultrasound <input type="checkbox"/> CT Scan Abdomen <input type="checkbox"/> Barium swallow <input type="checkbox"/> HIDA scan <input type="checkbox"/> Gallbladder Ultrasound <input type="checkbox"/> MRI _____ <input type="checkbox"/> Blood tests
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TURN OVER